

Add-ons, consults spared cuts in proposed fee schedule: Dip in revenue, many technical component codes in for a hit

Kevin B. O'Reilly

August 2016—The proposed Medicare physician fee schedule for 2017 features a slight dip in overall revenue for pathology groups and independent laboratories, but payment for flow cytometry and the technical components of prostate biopsy and surgical pathology work could fall by double-digit percentages if the Centers for Medicare and Medicaid Services stands pat with its final rule later this year.

Overall, the CMS estimates zero pay impact from changes to work and malpractice relative value units for pathologists on charges of \$1.1 billion or for independent labs on charges of \$701 million. However, the agency predicts an overall two percent drop in practice expense RVUs for pathologists and a five percent decline for independent labs. That follows an eight percent hike in aggregate pay in the 2016 fee schedule. (The CMS' proposed physician fee schedule, published July 15, can be found at <https://federalregister.gov/a/2016-16097>.)

Yet there are signs the CAP's efforts to communicate with the CMS directly and advocate for the value of pathologists' work through the AMA/Specialty Society Relative Value Scale Update Committee have had an impact in reversing earlier moves to cut Medicare payment for outside microslide consultations and add-on services such as immunohistochemistry, immunofluorescence, and fluorescence in situ hybridization.

In a July 14 CAP webinar, Council on Government and Professional Affairs chair Emily Volk, MD, MBA, noted the CMS has targeted 47 percent of pathology CPT codes for re-evaluation since 2006. Despite that intense scrutiny, Medicare pay for pathology codes has increased 51 percent during that time period.

"Over the last 10 years, there has been a 51 percent increase for pathologists, a 33 percent increase for pathologists billing with independent laboratories, and a 44 percent increase overall," Dr. Volk said during the webinar, which is available for viewing at <http://bit.ly/mpfs2017webinar> (registration required). "Perhaps not all of you have felt a 51 percent increase in your take-home pay, but the physician fee schedule includes payments through CMS only and does not include the clinical laboratory fee schedule payments and does not include private payers. However, we do understand that CMS has tremendous influence over what private payers do. And I just want to point out the work that CAP advocacy and our advocacy staff and volunteer members are doing in the arena of payment, in protecting the value of our services."



Dr. Volk

One area where greater cuts were averted was in pay for add-on services, which "have been a bone of contention between CAP and other pathology organizations and CMS," said W. Stephen Black-Schaffer, MD, vice chair of the CAP's Economic Affairs Committee.

"They [CMS] have wanted to apply a model, which may or may not work outside of pathology, to pathology services," Dr. Black-Schaffer said. The agency wanted to pay a substantial discount for additional slides examined in immunohistochemistry, immunofluorescence, or in situ hybridization work under the assumption "that there must be a substantial efficiency in looking for the second item."

"We have argued, and they have partially accepted at this point, that there is a de minimis increase in efficiency of looking for second and subsequent stains," he added.

The CMS currently applies a 24 percent discount from the first slide for add-on services in these areas. The proposed discount is 20 percent for 2017. While that may not seem like much, it will add up.



Dr. Black-Schaffer

"Even this change of four percent less discounting resulted in a nearly \$3 million projected payment increase to pathologists from Medicare based on the Medicare payment volume," Dr. Black-Schaffer said. "And the valuation of these codes is often reflected by payers beyond Medicare, so we anticipate this will be a benefit to pathologists even in their non-Medicare business."

Of the \$2.93 million in added pay for pathologists nationwide, \$2.75 million can be attributed to just one code, 88341, used to bill for subsequent IHC slides. The 20 percent discount for add-on services is still "overstated," Dr. Black-Schaffer said, and he and other CAP leaders "anticipate that CMS will continue to work with us on this matter."

The CMS also targeted pathology consultations and reports on referred slides prepared elsewhere. The agency proposed to cut the TC payment for code 88323, for example, by 19 percent and the global payment for the code by seven percent. But the payment for 88325—"consultation, comprehensive, with review of records and specimens, with report on referred material"—will rise nine percent to \$189.97.

"This is the sort of thing that has been very well supported by the other members of the AMA-RUC," Dr. Black-Schaffer tells CAP TODAY. "Many physicians raised their hands and spoke up about how absolutely necessary it was to have access to expert opinions from pathologists they knew and trusted in their particular referral centers before they took action, or didn't take action, based on problematic diagnoses."

After years of back and forth over Medicare payment for prostate biopsy pathology work, a mixed picture has emerged with the proposed rule. In 2015, the CMS said one code—G0416—would be used for all prostate biopsy specimens regardless of the number of specimens or the technique used to obtain the biopsy. But this new code did not include the TC revaluations that had been adopted for the previously used code, 88305. Now the CMS has gotten around to implementing those with a 19 percent proposed cut for 2017 (the biggest allowable percentage cut in one year), with more likely to come in 2018.

On the flip side, the CMS has proposed increasing pay for the professional component of the G0416 code, the 26 modifier, by 17 percent to \$184.96.



Dr. Myles

"We at CAP did think the professional work was significantly undervalued and advocated to increase the

professional component valuation,” said Jonathan Myles, MD, chair of the CAP’s Economic Affairs Committee. “We were successful at the RUC in our advocacy such that the RUC actually recommended a value of 4.00. That value was forwarded to CMS, and CMS decided to value it at 3.60 based on some of their intensity calculations in comparing the code to the 88305.”

Dr. Myles said the particular impact of the proposed G0416 changes will vary depending on how services are billed. Those who bill globally are in for a nine percent drop in pay, if the CMS adopts its proposed changes in the fall.

“If you’re a dash 26 biller, you’re going to see a nice increase,” he said. “If you’re a global biller, you will see an overall decrease in your payment for G0416.”

Two other areas that could see double-digit percentage pay cuts are TC for flow cytometry and tissue exams by pathologists. That is due to the agency’s re-evaluating the costs for the lysing reagent used in flow cytometry and hematoxylin and eosin stains used in surgical pathology work.

Five flow cytometry codes—88184, 88185, 88187, 88188, and 88189—could see the maximum 19 percent cuts in pay for 2017.

“The big driver here in reducing the technical component was the amount of lysing reagent that is used in these assays,” Dr. Myles said. The CMS analyzed how that pricey reagent is used and found that, typically, its cost is minimized per marker by laboratories running larger panels.

Two TC codes for tissue exams by pathologists—88307 and 88309—also are set for 19 percent cuts, while the CMS proposal seeks cuts ranging from nine percent to 16 percent for three other TC codes for tissue exams. (The CAP has prepared a table outlining the impact of the CMS’ proposed fee schedule changes, which is available at http://j.mp/2017prop_table.)

“We have had other stakeholders contact us already, and CAP will be working with the other stakeholders to engage with the CMS on this issue to try to mitigate some of these proposed decreases,” Dr. Myles said.

The proposed changes to the Medicare physician fee schedule come amid great uncertainty about how bundled payments and value-based models could affect pathology and laboratory medicine. There are also question marks about the long-delayed implementation of Protecting Access to Medicare Act requirements that laboratories submit private-market pay data to the CMS for its use in setting the clinical laboratory fee schedule.

In June, the CMS said any health care entity that received \$12,500 or more from Medicare for laboratory services over the six-month period between January and June 2016 must gather its private-market payment data. That information must be reported to the CMS through a yet to be completed Web portal between January and March 2017. The agency said about 95 percent of physician-office laboratories and about half of independent labs would not meet the \$12,500 threshold for mandatory reporting, raising questions about the reliability and representativeness of the data reported to the CMS.□

Kevin B. O'Reilly is CAP TODAY senior editor.